

HEPATITIS C CASE INVESTIGATION - Page 1 of 6

Indiana State Department of Health
State Form 52588 (R/4-06)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ☒ Not like this: ☒ Mark mistakes like this: ☒
- 4 Print capital letters only and numbers completely inside boxes.

A	2	C	3
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- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

Last Name

First Name

MI

Phone Number

Number & Street Address

City

State

ZIP Code

County

Date of Birth

Age

Race:

☐ Asian ☐ White

☐ Black or African American ☐ Other/Multiracial

☐ American Indian or Alaska Native ☐ Unknown

☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Sex:

☐ Male ☐ Female ☐ Unknown

Is Age in day/mo/yr?

☐ Days ☐ Months ☐ Years

Occupation

Phone of Employer/School/Day Care

Name of ☐ Employer ☐ School ☐ Day Care

Address of Employer/School/Day Care

City

State

ZIP Code

Section 2. Clinical Data

Name of Health Care Provider

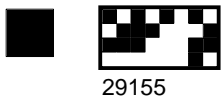
Address

City

State

ZIP Code

Phone Number



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Section 2. Clinical Data (continued)

Reason for testing (check all that apply):

☐ Symptoms of Acute Hepatitis

☐ Fever

☐ Diarrhea

☐ Nausea/Vomiting

☐ Abdominal Pain

☐ Pale Stool

☐ Dark Urine

☐ Fatigue

☐ Loss of Appetite

☐ Jaundice

☐ Other, specify: _____

☐ Evaluation of Elevated Liver Enzymes

☐ Screening of Asymptomatic Patient with Reported Risk Factors

☐ Blood/Organ Donor Screening

☐ Screening of Asymptomatic Patient with No Risk Factors (e.g., Patient Requested)

☐ Follow-up Testing for Previous Marker of Viral Hepatitis

☐ Prenatal Screening

☐ Other, specify: _____

☐ Unknown

____ / ____ / ____

Date of Onset

____ / ____ / ____

Date of Diagnosis

Duration of Symptoms in Days

____ / ____ / ____

Date First Positive Specimen Collected

Genotype: ☐ 1a ☐ 2a ☐ 4a ☐ 5 ☐ Other

☐ 1b ☐ 2b ☐ 3a ☐ 6 ☐ Unknown

Diagnostic tests (check all that apply):

Total antibody to hepatitis A virus (Total anti-HAV)

☐ Positive

☐ Negative

☐ Not Done

IgM antibody to hepatitis A virus (IgM anti-HAV)

☐ Positive

☐ Negative

☐ Not Done

Hepatitis B surface antigen (HBsAg)

☐ Positive

☐ Negative

☐ Not Done

Total antibody to hepatitis B core antigen (Total anti-HBc)

☐ Positive

☐ Negative

☐ Not Done

IgM antibody to hepatitis B core antigen (IgM anti-HBc)

☐ Positive

☐ Negative

☐ Not Done

Antibody to hepatitis C virus (anti-HCV)

☐ Positive

☐ Negative

☐ Not Done

If positive anti-HCV, list signal to cut-off ratio: _____

Supplemental anti-HCV assay (e.g., RIBA)

☐ Positive

☐ Negative

☐ Unknown

HCV RNA (e.g., PCR)

☐ Positive

☐ Negative

☐ Unknown

Antibody to hepatitis D virus (anti-HDV)

☐ Positive

☐ Negative

☐ Unknown

Antibody to hepatitis E virus (anti-HEV)

☐ Positive

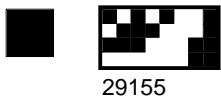
☐ Negative

☐ Unknown

Liver enzyme levels at time of diagnosis:

ALT (SGPT) Results: _____ Upper limit normal: _____ Date of ALT: ____ / ____ / ____

AST (SGOT) Results: _____ Upper limit normal: _____ Date of AST: ____ / ____ / ____



Section 2. Clinical Data (continued)

Was the patient hospitalized for hepatitis C?

☐ Yes ☐ No ☐ UnknownIf Yes, admission date: / / Discharge date: / / Hospital:

Did the patient die from hepatitis?

☐ Yes ☐ No ☐ UnknownIf Yes, date of death: / /

Section 3. Diagnosis

Please select one.

- ☐ Acute Hepatitis C
☐ Chronic Hepatitis C
☐ Resolved Hepatitis C Infection

Patient education, contact follow-up, and vaccination will be done by:

☐ Local Health Department ☐ Health Care Provider ☐ Other, specify:

Section 4. Risk Factors for Acute Hepatitis C Cases Only

During the 6 weeks-6 months prior to onset of symptoms:

Was the patient a contact of a person with confirmed or suspected hepatitis C infection?

☐ Yes ☐ No ☐ Unknown

If Yes, specify type of contact:

- ☐ Household Member (non-sexual)
☐ Sex Partner
☐ Other, specify:

Regardless of the patient's gender, how many

1. Male sex partners did the patient have?

☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown

2. Female sex partners did the patient have?

☐ 0 ☐ 1 ☐ 2-5 ☐ >5 ☐ Unknown

Did the patient inject drugs not prescribed by a doctor even if only once or a few times?

☐ Yes ☐ No ☐ Unknown

Did the patient use street drugs but not inject?

☐ Yes ☐ No ☐ Unknown

If Yes, what type of drug:

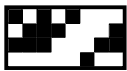
- ☐ Cocaine (including crack) ☐ Methamphetamine
☐ Heroin ☐ Other:

Did the patient undergo hemodialysis?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /

Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /



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Section 4. Risk Factors for Acute Hepatitis C Cases Only (continued)

Did the patient receive blood or blood products (transfusion)?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /

Did the patient receive any IV infusions and/or injections in an outpatient setting?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /

Did the patient have exposure to someone else's blood?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /
If Yes, specify

Did the patient have dental work or oral surgery?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /
If Yes, name of provider

Did the patient have surgery (other than oral surgery)?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /
If Yes, name of surgeon

Was the patient hospitalized overnight for any reason?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /
If Yes, name of hospital

Was the patient a resident in a long-term care facility?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /
If Yes, name of facility

Was the patient incarcerated for longer than 24 hours?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /

If Yes, type of facility (check all that apply):

☐ Prison ☐ Jail ☐ Juvenile Facility

Did the patient have any part of his/her body pierced (other than ear)?

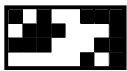
☐ Yes ☐ No ☐ UnknownIf Yes, date: / /

If Yes, indicate where the piercing was performed (check all that apply):

☐ Commercial Parlor/Shop ☐ Correctional Facility☐ Other, specify:

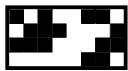
Did the patient have an ear pierced?

☐ Yes ☐ No ☐ UnknownIf Yes, date: / /



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State Form 52588 (R/4-06)**Section 4. Risk Factors for Acute Hepatitis C Cases Only (continued)****Did the patient have a tattoo placement?**☐ Yes ☐ No ☐ Unknown**If Yes, date:** / / **If Yes, indicate where the tattoo placement was performed (check all that apply):**☐ Commercial Parlor/Shop ☐ Correctional Facility☐ Other, specify: **Was the patient employed in a medical or dental field involving direct contact with human blood?**☐ Yes ☐ No ☐ Unknown**If Yes, check frequency of direct blood contact:**☐ Frequent (several times/week) ☐ Infrequent**Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?**☐ Yes ☐ No ☐ Unknown**If Yes, check frequency of direct blood contact:**☐ Frequent (several times/week) ☐ Infrequent**Section 5. Lifetime Risk Factors****Was the patient ever a contact of a person with confirmed or suspected hepatitis C infection?**☐ Yes ☐ No ☐ Unknown**If Yes, specify type of contact:**☐ Household Member (non-sexual)☐ Sex Partner☐ Other, specify: **Did the patient ever inject drugs not prescribed by a doctor even if only once or a few times?**☐ Yes ☐ No ☐ Unknown**Did the patient ever use street drugs but not inject?**☐ Yes ☐ No ☐ Unknown**If Yes, what type of drug:**☐ Cocaine (including crack) ☐ Methamphetamine☐ Heroin ☐ Other: **Did the patient ever undergo long-term hemodialysis?**☐ Yes ☐ No ☐ Unknown**If Yes, initial date:** / / **Was the patient ever employed in an occupation involving direct contact with human blood?**☐ Yes ☐ No ☐ Unknown**Was the patient ever treated for a sexually transmitted disease?**☐ Yes ☐ No ☐ Unknown**If Yes, in what year was the most recent treatment?** **Was the patient ever incarcerated for longer than 6 months duration?**☐ Yes ☐ No ☐ Unknown**If Yes, most recent year:** **Did the patient receive a blood transfusion prior to 1992?**☐ Yes ☐ No ☐ Unknown**Did the patient receive an organ transplant prior to 1992?**☐ Yes ☐ No ☐ Unknown**Did the patient receive clotting factor concentrates produced prior to 1987?**☐ Yes ☐ No ☐ Unknown



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Section 6. Vaccine Information

Did the patient ever receive hepatitis A vaccine?

☐ Yes ☐ No ☐ UnknownIf Yes, number of doses: Year the last dose was received:

Did the patient ever receive hepatitis B vaccine?

☐ Yes ☐ No ☐ UnknownIf Yes, number of doses: Year the last dose was received:

Section 7. Comments/Follow-up

Comments:

Investigator Name
Agency - - / /
Phone Number Date